

# Oakland County Health Plan Enrollment Form

For Employees Hired On or After 05/31/2003.  
Waiting Periods apply to those hired Part-time eligible.

DPDT \_\_\_\_\_  
DE \_\_\_\_\_

Employee ID #: \_\_\_\_\_

Please print your name below:

Your name as it is displayed on your Social Security Card  
 Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ M  Married   
 F  Single  Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone Work Social Security No. Full-time Part-time New Hire Re-hire Date of Hire

**Select One Medical Coverage**

Comprehensive Major Medical (CMM) (M1, M2, M3)  
 BC/BS Blue Preferred Plan (PPO) (P1, P2, P3)  
 No Medical Coverage (N1, N2, N3)  
 (Please complete "Medical Other Coverage" below)  
 Is Your Spouse A County Employee? (NS1, NS2, NS3)  
 (Please complete "Medical Other Coverage" below)

**Select One Dental Coverage**

Dental Coverage (789)  
 No Dental Coverage (16,17,18)  
 (Please complete "Dental Other Coverage" below)  
 Is Your Spouse A County Employee? (19,20,21)  
 (Please complete "Dental Other Coverage" below)  
 **Vision Coverage (required) - List Dependents below.** (10,11,12)

**IMPORTANT** - List Family Members you are covering. Please include last name if different from yours. Social Security Numbers are required.

NAME	SS# required	BIRTH DATE	Sex	Relationship
Spouse				

**Medical Other Coverage Verification:**

I am currently enrolled in \_\_\_\_\_ through my \_\_\_\_\_'s coverage with \_\_\_\_\_.

Health Policy Relationship Name of Company or Organization

**Dental Other Coverage Verification:**

I am currently enrolled in \_\_\_\_\_ through my \_\_\_\_\_'s coverage with \_\_\_\_\_.

Health Policy Relationship Name of Company or Organization

I apply on behalf of myself and eligible family members, as listed, for enrollment in the health plan selected above as currently offered through Oakland County. I hereby revoke all previous enrollment applications executed by me for hospital and medical coverage as made available by Oakland County.  
 Remember, no matter which health plan you choose, you elect a plan not a specific provider. If I selected the NO COVERAGE option, I realize my next opportunity to enroll may be as long as 1 year from this date.

I agree to the terms and conditions on the reverse side of this form and certify that the above information is true and correct.

Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Effective Date \_\_\_\_\_ Group/Suffix \_\_\_\_\_ Service Code \_\_\_\_\_

# ENROLLMENT FORM TERMS AND CONDITIONS

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Your signature on the front side of this form indicates your understanding that Oakland County will enroll you and your eligible dependents for hospital, surgical, medical and prescription drug coverage made available by Oakland County for which you are eligible and which you have not waived or canceled, with the health carrier you have elected and constitutes your authorization to Oakland County or any of its agents to release to all carriers or organizations, as applicable, the information contained on this form.

Your signature on the front side of this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare approved organization or provider of service to release any information requested with respect to a claim to the health carrier in which you are enrolled, or to the state or federal government, in situations involving processing or auditing of claims or investigation of fraud; in conformance with HIPPA.

Your signature on the front side of this form constitutes your authorization to Oakland County, until this authorization is revoked by you in writing, to deduct in advance each month from any earned or accrued wages due, such amount as may be necessary to make any contributions required of you. These include, by way of example, but not limited to, County health care contribution amounts.

If in any month you are not eligible to receive any earned or accrued wages or pension or retirement benefits, your signature on the front side of this form constitutes your agreement to pay in cash to Oakland County the full monthly subscription charges on or before the first of the month for which coverage is to be provided.

You may enroll your children by birth, legal adoption, legal guardianship or your spouse's children that meet all of the following: 1. Unmarried; 2. Legally reside with you; 3. You provide more than ½ their total support; 4. The child is a full time student OR the child has a gross income of less than 4 times the personal federal exemption amount. Such children can be covered up to December 31 of the year in which they turn 25 (in the case of legal guardianship, only while the guardianship is in force.) In the case of a qualified Medical Child Support Order, provide Employee Benefits in Human Resources with current documentation.

Other terms and conditions apply according to the specific plan in which you are enrolled.

This form should only be used for those employees hired on/after 05/31/2003 and does not apply to those in Bargaining Unit 10.

Revised: 01/2009